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## CHAPTER 2

# Interpersonal Learning

Interpersonal learning, as I define it, is a broad and complex therapeutic factor. It is the group therapy analogue of important therapeutic factors in individual therapy, such as insight, working through the transference, and the corrective emotional experience. But it also represents processes unique to the group setting. To define the concept of interpersonal learning and to describe the mechanism whereby it mediates therapeutic change in the individual, I first need to discuss three other concepts:

1. The importance of interpersonal relationships
2. The corrective emotional experience
3. The group as social microcosm.

### THE IMPORTANCE OF INTERPERSONAL RELATIONSHIPS

From whatever perspective we study human society—whether we scan humanity's broad evolutionary history or scrutinize the development of the single individual—we are at all times obliged to consider the human being in the matrix of his or her interpersonal relationships. There is convincing data from the study of primitive human cultures and nonhuman primates that humans have always lived in groups that have been characterized by intense and persistent relationships among members. Interpersonal behavior has

clearly been adaptive in an evolutionary sense: without deep, positive, reciprocal interpersonal bonds, neither individual nor species survival would have been possible.

John Bowlby, from his studies of the early mother-child relationship, concludes not only that attachment behavior is necessary for survival but that it is core, intrinsic, genetically built in.<sup>1</sup> If mother and infant are separated, both experience marked anxiety concomitant with their search for the lost object. If the separation is prolonged, the consequences for the infant will be profound. Goldschmidt, on the basis of an exhaustive review of the ethnographic evidence, stated:

Man is by nature committed to social existence, and is therefore inevitably involved in the dilemma between serving his own interests and recognizing those of the group to which he belongs. Insofar as this dilemma can be resolved it is resolved by the fact that man's self-interest can best be served through his commitment to his fellows. . . . Need for positive affect means that each person craves response from his human environment. It may be viewed as a hunger, not unlike that for food, but more generalized. Under varying conditions it may be expressed as a desire for contact, for recognition and acceptance, for approval, for esteem, or for mastery. . . . As we examine human behavior, we find that persons not only universally live in social systems, which is to say they are drawn together, but also universally act in such ways as to attain the approval of their fellow men.<sup>2</sup>

Similarly, a century ago the great American psychologist-philosopher, William James, said:

We are not only gregarious animals liking to be in sight of our fellows, but we have an innate propensity to get ourselves noticed, and noticed favorably, by our kind. No more fiendish punishment could be devised, were such a thing physically possible, than that one should be turned loose in society and remain absolutely unnoticed by all the members thereof.<sup>3</sup>

Indeed, James's speculations have been substantiated time and again by contemporary research that documents the pain and the adverse consequences of loneliness. There is, for example, persuasive evidence that the rate for virtually every major cause of death is significantly higher for the lonely, the single, the divorced, and the widowed.<sup>4</sup>

All modern American schools of dynamic psychotherapy are interpersonally based and draw heavily, though implicitly, from the American neo-Freudian theorists Karen Horney, Erich Fromm, and, especially and most systematically, Harry Stack Sullivan and his interpersonal theory of psychiatry.<sup>5</sup>

Despite Sullivan's seminal importance, contemporary generations of therapists rarely read him. For one thing, his language is often obscure (though there are excellent renderings of his work into plain English);<sup>6</sup> for another, his work has so pervaded contemporary psychotherapeutic thought that his original writings seem overly familiar or obvious. However, in the recent merging of cognitive and interpersonal approaches in psychotherapy, there has been a resurgence of interest in his writings.<sup>7</sup>

Sullivan's formulations are exceedingly helpful for understanding the group therapeutic process. Although a comprehensive discussion of his interpersonal theory is beyond the scope of this book, I will describe a few key concepts here. Sullivan contends that the personality is almost entirely the product of interaction with other significant human beings. The need to be closely related to others is as basic as any biological need and is, in the light of the prolonged period of helpless infancy, equally necessary to survival. *The developing child, in the quest for security, tends to cultivate and to stress those traits and aspects of the self that meet with approval, and will squelch or deny those that meet with disapproval.* Eventually the individual develops a concept of the self (self-dynamism) based on these perceived appraisals of significant others.

The self may be said to be made up of reflected appraisals. If these were chiefly derogatory, as in the case of an unwanted child who was never loved, or of a child who has fallen into the hands of foster parents who have no real interest in him as a child; as I say, if the self-dynamism is made up of experience which is chiefly derogatory, it will facilitate hostile, disparaging appraisals of other people and it will entertain disparaging and hostile appraisals of itself.<sup>8</sup>

This process of constructing our self-regard on the basis of reflected appraisals that we read in the ideas of important others continues, of course, through the developmental cycle. In their study of adolescents, Grunebaum and Solomon have stressed that satisfying peer relationships and self-esteem are inseparable concepts.<sup>9</sup>

Sullivan used the term *parataxic distortions* to describe individuals' proclivity to distort their perceptions of others. A parataxic distortion occurs in an interpersonal situation *when one person relates to another not on the basis of the realistic attributes of the other but on the basis of a personification existing chiefly in the former's own fantasy.* Though parataxic distortion is similar to the concept of transference, it differs in two important ways. First, the scope is broader: it refers not only to an individual's distorted view of the therapist but to all interpersonal relationships (including, of course, distorted relationships among group members). Second, the theory of origin is broader: parataxic distortion is constituted not only of the simple transferring onto contemporary

relationships of attitudes toward real-life figures of the past but also of the distortion of interpersonal reality in response to intrapersonal needs. I will generally use the two terms interchangeably: despite the imputed difference in origins, *transference* and *parataxic distortion* may be considered operationally identical. Furthermore, many therapists today use the term *transference* to refer to all interpersonal distortions rather than confining its use to the patient-therapist relationship (see chapter 7).

Interpersonal (that is, *parataxic*) distortions tend to be self-perpetuating. For example, an individual with a derogatory, debased self-image may, through selective inattention or projection, incorrectly perceive another to be a harsh, rejecting figure. Moreover, the process compounds itself because that individual may then gradually develop mannerisms and behavioral traits—for example, servility, defensive antagonism, or condescension—that eventually will cause others to become, in reality, harsh and rejecting. This sequence of circular causality,<sup>10</sup> commonly referred to as the *self-fulfilling prophecy*, is important and often plays a significant role in group therapy.

Parataxic distortions, in Sullivan's view, are modifiable primarily through *consensual validation*—that is, through comparing one's interpersonal evaluations with those of others. Consensual validation is also an important concept in group therapy. Not infrequently a group member alters distortions after sampling the other members' views of some important incident.

This brings us to Sullivan's view of the therapeutic process. He suggests that the proper focus of research in mental health is the study of processes that involve or go on between people.<sup>11</sup> Mental disorder, or psychiatric symptomatology in all its varied manifestations, should be translated into interpersonal terms and treated accordingly. "Mental disorder" refers to interpersonal processes that are either inadequate to the social situation or excessively complex because of the introduction of illusory persons into the situations.<sup>12</sup> Accordingly, psychiatric treatment should be directed toward the *correction of interpersonal distortions*, thus enabling the individual to lead a more abundant life, to participate collaboratively with others, to obtain interpersonal satisfactions in the context of realistic, mutually satisfying interpersonal relationships: "One achieves mental health to the extent that one becomes aware of one's interpersonal relationships."<sup>13</sup> Psychiatric cure is the "expanding of the self to such final effect that the patient as known to himself is much the same person as the patient behaving to others."<sup>14</sup>

These ideas—that therapy is broadly interpersonal, both in its goals and in its means—are exceedingly germane to group therapy. That does not mean that all, or even most, patients entering group therapy ask explicitly for help in their interpersonal relationships. Yet I have observed that the therapeutic goals of patients, somewhere between the third and the sixth months of group therapy, often undergo a shift. Their initial goal, relief of suffering, is modified

and eventually replaced by new goals, usually interpersonal in nature. Goals may change from wanting relief from anxiety or depression to wanting to learn to communicate with others, to be more trusting and honest with others, to learn to love.

The goal shift from relief of suffering to change in interpersonal functioning is an essential early step in the dynamic therapeutic process. It is important in the thinking of the therapist as well. Therapists cannot, for example, treat depression *per se*: depression offers no effective therapeutic handhold, no rationale for examining interpersonal relationships, which, as I hope to demonstrate, is the key to the therapeutic power of the therapy group. It is necessary, first, to translate depression into interpersonal terms and then to treat the underlying interpersonal pathology. Thus, the therapist translates depression into its interpersonal issues—for example, passive dependency, isolation, obsequiousness, inability to express anger, hypersensitivity to separation—and then addresses those interpersonal issues in therapy.

Sullivan's statement of the overall process and goals of therapy is deeply consistent with those of interactional group therapy. However, the emphasis on the patient's understanding of the past, of the genetic development of those maladaptive interpersonal stances, may be less crucial in group therapy than in the individual setting where Sullivan worked (see chapter 6).

The theory of interpersonal relationships has become so much an integral part of the fabric of psychiatric thought that it needs no further underscoring. People need people—for initial and continued survival, for socialization, for the pursuit of satisfaction. No one—not the dying, not the outcast, not the mighty—transcends the need for human contact.

During my many years of leading groups of patients who all had some advanced form of cancer,<sup>15</sup> I was repeatedly struck by the realization that, in the face of death, we dread not so much nonbeing or nothingness but the accompanying utter loneliness. Dying patients may often be haunted by interpersonal concerns—at being abandoned, for example, even shunned, by the world of the living. One patient, for example, had planned to give a large evening social function and learned that very morning that her cancer, heretofore believed contained, had metastasized. She kept the information secret and gave the party, all the while dwelling on the horrible thought that the pain from her disease would get so unbearable that she would become less human and, finally, unacceptable to others. Another patient with severe heart disease who had had a pacemaker and a ventricular defibrillator inserted felt severe anxiety. His greatest terror was social in nature: he worried about going into ventricular tachycardia in public and needing a cardiac jolt, which would humiliate him in front of his friends and associates. He lost sight of the anxiety of the real threat—that his heart might not be revived and that death could come capriciously, at any moment.

I agree with Elisabeth Kübler-Ross that the question is not *whether* but *how* to tell a patient openly and honestly about a fatal illness. The patient is always informed covertly that he or she is dying by the demeanor, by the shrinking away, of the living.<sup>16</sup>

The isolation of the dying is often double-edged. Patients themselves often avoid those they most cherish, fearing that they will drag their family and friends into the quagmire of their despair. Thus they avoid morbid talk, develop an alibi, cheery facade, and keep their fears to themselves. Their friends and family contribute to the isolation by pulling back, by not knowing how to speak to the dying, by not wanting to upset them or themselves.

Physicians often add to the isolation by keeping patients with advanced cancer at a considerable psychological distance—perhaps to avoid their sense of failure and futility, perhaps also to avoid dread of their own death. They make the mistake of concluding that, after all, there is nothing more they can do. Yet from the patient's standpoint, this is the very time when the physician is needed the most, not for technical aid but for sheer human presence. What the patient needs is to make contact, to be able to touch others, to voice concerns openly, to be reminded that he or she is not only *apart from* but also a *part of*.

The outcasts—those individuals thought to be so inured to rejection that their interpersonal needs have become heavily calloused—have compelling social needs, too. I once had an experience in a prison that provided me with a forceful reminder of the ubiquitous nature of this human need. An untrained psychiatric technician consulted me about his therapy group, composed of twelve inmates. The members of the group were all hardened recidivists, whose offenses ranged from aggressive sexual violation of a minor to murder. The group, he complained, was sluggish and persisted in focusing on extraneous, extragroup material. I agreed to observe his group and suggested that first he obtain some sociometric information by asking each member privately to rank-order everyone in the group for general popularity. (I had hoped that the discussion of this task would induce the group to turn its attention upon itself.) Although we had planned to discuss these results before the next group session, unexpected circumstances forced us to cancel our pre-session consultation.

During the next group meeting, the therapist, enthusiastic but professionally inexperienced and insensitive to interpersonal needs, announced that he had decided simply to read aloud the results of the popularity poll. Hearing this, the group members grew agitated and fearful. They made it clear that they did not wish to know the results. Several members spoke so vehemently of the devastating possibility that they might appear at the bottom of the list that the therapist quickly and permanently abandoned his plan of reading the list aloud.

I suggested an alternative plan for the next meeting: each member would

indicate whose vote he cared about most and then explain his choice. This device, also, was too threatening, and only one-third of the members ventured a choice. Nevertheless, the group shifted to an interactional level and developed a degree of tension, involvement, and exhilaration previously unknown. These men had received the ultimate message of rejection from society at large: they were imprisoned, segregated, and explicitly labeled as outcasts. To the casual observer, they seemed hardened, indifferent to the subtleties of interpersonal approval and disapproval. Yet they cared, and cared deeply.

The need for acceptance by and interaction with others is no different among people at the opposing pole of human fortunes—those who occupy the ultimate realms of power, renown, or wealth. I once worked with an enormously wealthy patient for three years. The major issues revolved about the wedge that money created between herself and others. Did anyone value her for herself rather than her money? Was she continually being exploited by others? To whom could she complain of the burdens of a forty-million-dollar fortune? The secret of her wealth kept her isolated from others. And gifts! How could she possibly give appropriate gifts without having others feel either disappointed or awed? There is no need to belabor the point; the loneliness of the very privileged is common knowledge. (Loneliness is, incidentally, not irrelevant to the group therapist; in chapter 7, I will discuss the loneliness inherent in the role of group leader.)

Every group therapist has, I am sure, encountered patients who profess indifference to or detachment from the group. They proclaim: "I don't care what they say or think or feel about me; they're nothing to me; I have no respect for the other members," or words to that effect. My experience has been that if I can keep such patients in the group long enough, another aspect inevitably surfaces. They are concerned at a very deep level about the group. One patient who maintained her indifferent posture for many months was once invited to ask the group her secret question, the one question she would like most of all to place before the group. To everyone's astonishment, this seemingly aloof, detached woman posed this question: "How can you put up with me?"

Many patients anticipate meetings with great eagerness or with anxiety; some feel too shaken afterward to drive home or to sleep that night; many have imaginary conversations with the group during the week. Moreover, this engagement with other members is often long-lived; I have known many patients who think and dream about the group members months, even years, after the group has ended.

In short, people do not feel indifferent toward others in their group for long. And patients do not quit the therapy group because of boredom. Believe scorn, contempt, fear, discouragement, shame, panic, hatred! Believe any of these! But never believe indifference!

In summary, then, I have reviewed some aspects of personality development, mature functioning, psychopathology, and psychiatric treatment from the point of view of interpersonal theory. Many of the issues that I have raised have a vital bearing on the therapeutic process in group therapy: the concept that mental illness emanates from disturbed interpersonal relationships, the role of consensual validation in the modification of interpersonal distortions, the definition of the therapeutic process as an adaptive modification of interpersonal relationships, and the enduring nature and potency of the human being's social needs. Let us now turn to the corrective emotional experience, the second of the three concepts necessary to understand the therapeutic factor of interpersonal learning.

## THE CORRECTIVE EMOTIONAL EXPERIENCE

In 1946, Franz Alexander, when describing the mechanism of psychoanalytic cure, introduced the concept of the "corrective emotional experience." The basic principle of treatment, he stated, "is to expose the patient, under more favorable circumstances, to emotional situations that he could not handle in the past. The patient, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of previous experience."<sup>17</sup> Alexander insisted that intellectual insight alone is insufficient; there must be an emotional component and systematic reality testing as well. Patients, while affectively interacting with their therapist in a distorted fashion because of transference, gradually must become aware of the fact that "these reactions are not appropriate to the analyst's reactions, not only because he (the analyst) is objective, but also because he is what he is, a person in his own right. They are not suited to the situation between patient and therapist, and they are equally unsuited to the patient's current interpersonal relationships in his daily life."<sup>18</sup> In general, this is the widely accepted position in contemporary psychotherapy. Even among psychoanalysts—who historically tend to rely most heavily on the mutative power of pure interpretation—there are few, since Greenson in the 1960s, who deny that the human, personal qualities of the therapists are as important as the content of the insight they provide.<sup>19</sup>

These basic principles—the importance of the emotional experience in therapy and the patient's discovery, through reality testing, of the inappropriateness of his or her interpersonal reactions—are as crucial in group therapy as in individual therapy, possibly more so because the group setting offers far more opportunities for the generation of corrective emotional experiences. In the individual setting, the corrective emotional experience, valuable as it is, may

be hard to come by because of the insularity and unreality of the patient-therapist relationship. (I believe Alexander was aware of that, because at one point he suggested that the analyst may have to be an actor, may have to play a role in order to create the desired emotional atmosphere.)<sup>20</sup>

No such simulation is necessary in the therapy group, which contains many built-in tensions—tensions whose roots reach deeply into primeval layers: sibling rivalry, competition for leaders'/parents' attention, the struggle for dominance and status, sexual tensions, parataxic distortions, and differences in social class, education, and values among the members. But the evocation and expression of raw affect is not sufficient: it has to be transformed into a corrective emotional experience. For that to occur two conditions are required: (1) the members must experience the group as sufficiently safe and supportive so that these tensions may be openly expressed; (2) there must be sufficient engagement and honest feedback to permit effective reality testing.

Over many years of clinical work, I have made it a practice to interview patients after they have completed group therapy. I always inquire about some critical incident, a turning point or the most helpful single event in therapy. Although "critical incident" is not synonymous with therapeutic factor, clearly the two are not unrelated and much may be learned from an examination of single important events. My patients almost invariably select an incident that is highly laden emotionally and involves some other group member, rarely the therapist.

The most common type of incident my patients report (as did patients described by Frank and Ascher)<sup>21</sup> involves a sudden expression of strong dislike or anger toward another member. In each instance, communication was maintained, the storm was weathered, and the patient experienced a sense of liberation from inner restraints as well as an enhanced ability to explore more deeply his or her interpersonal relationships.

The important characteristics of such critical incidents were:

1. The patient expressed strong negative affect.
2. This expression was a unique or novel experience for the patient.
3. The patient had always dreaded the expression of anger. Yet no catastrophe ensued: no one left or died; the roof did not collapse.
4. Reality testing ensued. The patient realized either that the anger expressed was inappropriate in intensity or direction, or that prior avoidance of affect expression had been irrational. He or she may or may not have gained some insight, that is, learned the reasons accounting either for the inappropriate affect or for his or her prior avoidance of affect experience or expression.
5. The patient was enabled to interact more freely and to explore interpersonal relationships more deeply.

The second most common type of critical incident described by my patients also involved strong affect—but, in these instances, *positive* affect. For example, a schizoid patient ran after and comforted a distressed patient who had bolted out of the room; later he spoke of how profoundly he was affected by learning that he could care for and help someone else. Others similarly spoke of discovering their aliveness or of feeling in touch with themselves. These incidents had in common the following characteristics:

1. The patient expressed strong positive affect—an unusual occurrence.
2. The feared catastrophe did not occur—derision, rejection, engulfment, the destruction of others.
3. The patient discovered a previously unknown part of the self and thus was enabled to relate to others in a new fashion.

The third most common category of critical incident is similar to the second. Patients recalled an incident, usually involving self-disclosure, that plunged them into greater involvement with the group. For example, a previously withdrawn, reticent patient who had missed a couple of meetings disclosed to the group how desperately he wanted to hear the group members say that they had missed him during his absence. Others, too, in one fashion or another openly asked the group for help.

To summarize, the corrective emotional experience in group therapy has several components:

1. A strong expression of emotion, which is interpersonally directed and is a risk taken by the patient.
2. A group supportive enough to permit this risk taking.
3. Reality testing, which allows the patient to examine the incident with the aid of consensual validation from the other members.
4. A recognition of the inappropriateness of certain interpersonal feelings and behavior or of the inappropriateness of certain avoided interpersonal behavior.
5. The ultimate facilitation of the individual's ability to interact with others more deeply and honestly.

Therapy is an emotional and a corrective experience. This dual nature of the therapeutic process is of elemental significance, and I will return to it again and again in this text. We must experience something strongly; but we must also, through our faculty of reason, understand the implications of that emotional experience.

This formulation has direct relevance to the concept of the here-and-now, a

key concept of group therapy that I will discuss in depth in chapter 6. Here I will state only this basic premise: *to the degree that the therapy group focuses on the here-and-now, it increases in power and effectiveness.*

But if the here-and-now focus (that is, a focus on what is happening in this room in the immediate present) is to be therapeutic, it must have two components: the group members must experience one another with as much spontaneity and honesty as possible, and they must also *reflect back upon that experience*. This reflecting back, this self-reflective loop, is crucial if an emotional experience is to be transformed into a therapeutic one. As we shall see in chapter 5, when we discuss the therapist's tasks, most groups have little difficulty in entering the emotional stream of the here-and-now; it is the therapist's job to keep directing the group toward the self-reflective aspect of that process.

The mistaken assumption that a strong emotional experience is *in itself* a sufficient force for change is seductive, as well as venerable. Modern psychotherapy was conceived in that very error: the first description of dynamic psychotherapy (Freud and Breuer's 1895 book on hysteria)<sup>22</sup> described a method of cathartic treatment based on the conviction that hysteria is caused by a traumatic event to which the individual has never fully responded emotionally. Since illness was supposed to be caused by strangulated affect, treatment thus consisted of giving a voice to the stillborn emotion. It was not long before Freud recognized their error: emotional expression, though necessary, is not a *sufficient* condition for change. Freud's discarded ideas, tossed carelessly away, have refused to die and have been the seed for a continuous fringe of therapeutic ideologies. The Viennese *fin-de-siècle* cathartic treatment still lives today in the approaches of primal scream, bioenergetics, and the many group leaders who place an exaggerated emphasis on emotional catharsis.

My colleagues and I conducted an intensive investigation of the process and outcome of many of the encounter techniques popular in the 1970s (see chapter 16 for a description of this research), and our findings provide much support for the dual emotional-intellectual components of the psychotherapeutic process.<sup>23</sup>

We explored, in a number of ways, the relationship between each member's experience in the group and his or her outcome. For example, we asked the members to reflect, retrospectively, on those aspects of the group experience that they deemed most pertinent to their change. We also asked them during the course of the group (at the end of each meeting) to describe which event that meeting had had the most personal significance. When we correlated the type of event with outcome, we obtained surprising results that disconfirmed many of the current stereotypes about the prime ingredients of the successful encounter group experience. Although emotional experiences (expression and

experiencing of strong affect, self-disclosure, giving and receiving feedback) were considered extremely important, they did not distinguish successful from unsuccessful group members. In other words, the members who were unchanged or even had a destructive experience were as likely as successful members to value highly the emotional incidents of the group.

What types of experiences *did* differentiate the successful from the unsuccessful members? There was clear evidence that a *cognitive component* was essential; some type of cognitive map was needed, some intellectual system that framed the experience and made sense of the emotions evoked in the group. (See chapter 16 for a full discussion of this result.) That these findings occurred in groups led by leaders who did not attach much importance to the intellectual component speaks strongly for its being part of the core, and not the facade, of the change process.<sup>24</sup>

## THE GROUP AS SOCIAL MICROCOSM

A freely interactive group, with few structural restrictions, will, in time, develop into a social microcosm of the participant members. Given enough time, group members will begin to be themselves: they will interact with the group members as they interact with others in their social sphere, will create in the group the same interpersonal universe they have always inhabited. In other words, patients will, over time, automatically and inevitably begin to display their maladaptive interpersonal behavior in the therapy group. There is no need for them to describe or give a detailed history of their pathology: *they will sooner or later enact it before the group members' eyes.*

This concept is of paramount importance in group therapy and constitutes a keystone upon which rests the entire approach to group therapy. It is widely accepted by clinicians, although each therapist's perception and interpretation of group events and descriptive language will be determined by his or her school of conviction. Thus, Freudians may see patients manifesting their oral, sadistic, or masochistic needs in their relationship to other members; object-relations theorists may focus on the patients' manifesting the defenses of splitting, projective identification, idealization, devaluation; correctional workers may see conning, exploitative behavior; social psychologists may see manifold bids for dominance, affection, or inclusion; Adlerians may speak more of feelings of inferiority and compensatory behavior and of masculine and feminine guiding lines, and attend more carefully to birth order (youngest sister, older brother, and so on) and the sibling relationships—both historically and how they are played out in the group;<sup>25</sup> whereas students of Horney may see the detached, resigned person putting energies into acting noncommittal and indif-

ferent, or the arrogant-vindictive person struggling to prove him- or herself right by proving others wrong.<sup>26</sup>

The important point is that, regardless of the type of conceptual spectacles worn by the therapist-observer, each member's interpersonal style will eventually appear in his or her transactions in the group. Some styles result in interpersonal friction that will be manifest early in the course of the group. Individuals who are, for example, angry, vindictive, harshly judgmental, self-effacing, or grandly coquettish will generate considerable interpersonal static even in the first few meetings. Their maladaptive social patterns will come under the group's scrutiny far earlier than will those of individuals who may be equally or more severely troubled but who, for example, subtly exploit others or achieve intimacy to a point but then, becoming frightened, disengage themselves.

The initial business of a group usually consists of dealing with the members whose pathology is most interpersonally blatant. Some interpersonal styles become crystal-clear from a single transaction; others, from a single group meeting; others require months of observation to understand. The development of the ability to identify and put to therapeutic advantage maladaptive interpersonal behavior as seen in the social microcosm of the small group is one of the chief tasks of a training program for group psychotherapists. Some clinical examples may make these principles more graphic.\*

### *The Grand Dame*

Valerie, a twenty-seven-year-old musician, sought therapy with me primarily because of severe marital discord of several years' standing. She had had considerable, unrewarding individual and hypnotic uncovering therapy. Her husband, she reported, was an alcoholic who was reluctant to engage her socially, intellectually, or sexually. Now the group could have, as some groups do, investigated her marriage interminably. The members might have taken a complete history of the courtship, of the evolution of the discord, of her husband's pathology, of her reasons for marrying him, of her role in the conflict; they might have given advice for new behavior or for a trial or permanent separation.

But all this historical, problem-solving activity would have been in vain: this entire line of inquiry not only disregards the unique potential of therapy groups but is also based on the highly questionable premise that a patient's account of a marriage is even reasonably accurate. Groups that function in this manner fail to help the protagonist and also suffer demoralization because

\*In order to ensure each patient's right to privacy, I have altered certain facts, such as name, occupation, and age. In addition, the interaction described in the text is not verbatim but has been reconstructed from detailed clinical notes taken after each therapy meeting.

of the ineffectiveness of a problem-solving, historical group therapy approach. Let us instead observe Valerie's behavior as it unfolds in the here-and-now of the group.

Valerie's group behavior was flamboyant. First, there was her grand entrance, always five or ten minutes late. Bedecked in fashionable but flashy garb, she would sweep in, sometimes throwing kisses, and immediately begin talking, oblivious to whether some other member was in the midst of a sentence. Here was narcissism in the raw! Her world view was so solipsistic that it did not take in the possibility that life could have been going on in the group before her arrival.

After very few meetings, Valerie began to give gifts: to an obese female member, a copy of a new diet book; to a woman with strabismus, the name of a good ophthalmologist; to an effeminate gay patient, a subscription to *Field and Stream* magazine (to masculinize him); to a twenty-four-year-old virginal male, an introduction to a promiscuous divorced friend of hers. Gradually it became apparent that the gifts were not duty-free. For example, she pried into the relationship between the young man and her divorced friend and insisted on serving as a go-between, thus exerting considerable control over both individuals.

Her efforts to dominate soon colored all of her interactions in the group. I became a challenge to her, and she made various efforts to control me. By sheer chance, a few months previously I had seen her sister in consultation and referred her to a competent therapist, a clinical psychologist. In the group Valerie congratulated me for the brilliant tactic of sending her sister to a psychologist; I must have divined her deep-seated aversion to psychiatrists. Similarly, on another occasion, she responded to a comment from me, "How perceptive you were to have noticed my hands trembling."

The trap was set! In fact, I had neither "divined" her sister's alleged aversion to psychiatrists (I had simply referred her to the best therapist I knew), nor noted Valerie's trembling hands. If I silently accepted her undeserved tribute, then I would enter into a dishonest collusion with Valerie; if, on the other hand, I admitted my insensitivity either to the trembling of the hands or to the sister's aversion, then in a sense I would also be bested. She would control me either way! In such situations, the therapist has only one real option: to change the frame and to comment upon the process—the nature and the meaning of the entrapment. (I will have a great deal more to say about relevant therapist technique in chapter 6.)

Valerie vied with me in many other ways. Intuitive and intellectually gifted, she became the group expert on dream and fantasy interpretation. On one occasion she saw me between group sessions to ask whether she could use my name to take a book out of the medical library. On one level the request was reasonable: the book (on music therapy) was related to her profession; further-

more, having no university affiliation, she was not permitted to use the library.

However, in the context of the group process, the request was complex in that she was testing limits: granting her request would have signaled to the group that she had a special and unique relationship with me. I clarified these considerations to her and suggested further discussion in the next session. Following this perceived rebuttal, however, she called the three male members of the group at home and, after swearing them to secrecy, arranged to see them. She engaged in sexual relations with two; the third, a gay man, was not interested in her sexual advances but she launched a mighty seduction attempt nonetheless.

The following group meeting was horrific. Extraordinarily tense and unproductive, it demonstrated the axiom (to be discussed later) that *if something important in the group is being actively avoided, then nothing else of import gets talked about either*. Two days later Valerie, overcome with anxiety and guilt, asked for an individual session with me and made a full confession. It was agreed that the whole matter should be discussed in the next group meeting.

Valerie opened the next meeting with the words: "This is confession day! Go ahead, Charles!" and then later, "Your turn, Louis." Each man performed as she bade him and, later in the meeting, received from her a critical evaluation of his sexual performance. A few weeks later, Valerie let her estranged husband know what had happened, and he sent threatening messages to all three men. That was the last straw! The members decided they could no longer trust her and, in the only such instance I have known, voted her out of the group. (She continued her therapy by joining another group.) The saga does not end here, but perhaps I have gone far enough to illustrate the concept of the group as social microcosm.

Let us summarize. The first step was that Valerie clearly displayed her *interpersonal pathology* in the group. Her narcissism, her need for adulation, her need to control, her sadistic relationship with men—the entire tragic behavioral scroll—unrolled in the here-and-now of therapy. The next step was *reaction and feedback*. The men expressed their deep humiliation and anger at having to "jump through a hoop" for her and at receiving "grades" for their sexual performance. They drew away from her. They began to reflect: "I don't want a report card every time I have sex. It's controlling, like sleeping with my mother! I'm beginning to understand more about your husband moving out!" and so on. The others in the group, the female members and the therapists, shared the men's feelings about the wantonly destructive course of Valerie's behavior—destructive for the group as well as for herself.

Most important of all, she had to deal with this fact: she had joined a group of troubled individuals who were eager to help each other and whom she grew to like and respect; yet, in the course of several weeks, she had so poisoned her environment that, against her conscious wishes, she became a pariah, an

outcast from a group that had had the potential of being very helpful to her. Facing and working through these issues in her subsequent therapy group enabled her to make substantial personal changes and to employ much of her considerable potential constructively in her later relationships and endeavors.

### *The Man Who Liked Robin Hood*

Ron, a forty-eight-year-old attorney who was separated from his wife, entered therapy because of depression, anxiety, and intense feelings of loneliness. His relationships, with both men and women, were highly problematic. He yearned for a close male friend but had not had one since high school. His current relationships with men assumed one of two forms: either he and the other man related in a highly competitive, antagonistic fashion, which veered dangerously close to combativeness, or he assumed an exceedingly dominant role and soon found the relationship empty and dull.

His relationships with women had always followed a predictable sequence: instant attraction, a crescendo of passion, a rapid withering. His love for his wife had decayed years ago and he was currently in the midst of a painful divorce.

Intelligent and highly articulate, Ron immediately assumed a position of great influence in the group. He offered a continuous stream of useful and thoughtful observations to the other members, yet kept his own pain and his own needs well concealed. He requested nothing and accepted nothing from me or my co-therapist. In fact, each time I set out to interact with Ron, I felt myself bracing for battle. His antagonistic resistance was so great that for months my major interaction with him consisted of repeatedly requesting him to examine his reluctance to experience me as someone who could offer help.

"Ron," I asked, giving it my best shot, "let's understand what's happening. You have many areas of unhappiness in your life. I'm an experienced therapist, and you come to me for help. You come regularly, you never miss a meeting, you pay me for my services, yet you systematically prevent me from helping. Either you so hide your pain that I find little to offer you, or when I do extend some help, you reject it in one fashion or another. Reason dictates that we should be allies, working together to help you. How does it come about that we are adversaries?"

But even that failed to alter our relationship. Ron seemed bemused and skillfully and convincingly speculated that I might be identifying one of my problems rather than his. His relationship with the other group members was characterized by his insistence on seeing them outside the group. He systematically arranged for some extragroup activity with each of the members. He was a pilot and took some members flying, others sailing, others to lavish dinners; he gave legal advice to some and became romantically involved with one of

the female members; and (the final straw) he invited my co-therapist, a female psychiatric resident, for a skiing weekend.

Furthermore, he refused to examine his behavior or to discuss these extragroup meetings in the group, even though the pregroup preparation (see chapter 12) had emphasized to all the members that such unexamined, undiscussed extragroup meetings generally sabotage therapy.

After one meeting when we pressured him unbearably to examine the meaning of the extragroup invitations, especially the skiing invitation to my co-therapist, he left the session confused and shaken. On his way home, Ron unaccountably began to think of Robin Hood, his favorite childhood story but something he had not thought about for decades.

Following an impulse, he drove directly to the children's section of the nearest public library to sit in a small child's chair and read the story one more time. In a flash, the meaning of his behavior was illuminated! Why had the Robin Hood legend always fascinated and delighted him? Because Robin Hood rescued people, especially women, from tyrants!

That motif had played a powerful role in his interior life beginning with the Oedipal struggles in his own family. Later, in early adulthood, he built up a successful law firm by first assisting in a partnership and then enticing his boss's employees to work for him. He had often been most attracted to women who were attached to some powerful man. Even his motives for marrying were blurred; he could not distinguish between love for his wife and desire to rescue her from a tyrannical father.

The first stage of interpersonal learning is *pathology display*. Ron's characteristic modes of relating to both men and women unfolded vividly in the microcosm of the group. His major interpersonal motif was to struggle with and to vanquish other men. He competed openly and, because of his intelligence and his great verbal skills, soon procured the dominant role in the group. He then began to mobilize the other members in the final conspiracy: the unseating of the therapist. He formed close alliances through extragroup meetings and through placing other members in his debt by offering favors. Next he endeavored to capture "my women"—first the most attractive female member and then my co-therapist.

Not only was Ron's interpersonal pathology displayed in the group, but so also were its adverse, self-defeating consequences. His struggles with men resulted in the undermining of the very reason he had come to therapy: to obtain help. In fact, the competitive struggle was so powerful that any help I extended him was experienced not as help but as defeat, a sign of weakness.

Furthermore, the microcosm of the group revealed the consequences of his actions on the texture of his relationship with his peers. In time the other members became aware that Ron did not really relate to them. He only appeared to relate but, in actuality, was using them as a way of relating to me,

the powerful and feared male in the group. The others soon felt used, felt the absence of a genuine desire in Ron to know them, and gradually began to distance themselves from him. Only after Ron was able to understand and to alter his intense and distorted ways of relating to me was he able to turn to and relate in good faith to the other members of the group.

### "Those Damn Men"

Linda, forty-six years old and thrice divorced, entered the group because of anxiety and severe functional gastrointestinal distress. Her major interpersonal issue was her tormented, self-destructive relationship with her current boyfriend. In fact, throughout her life she had encountered a long series of men (father, brothers, bosses, lovers, and husbands) who had abused her both physically and psychologically. Her accounts of the abuse that she had suffered, and suffered still, at the hands of men were harrowing.

The group could do little to help her, aside from applying balm to her wounds and listening empathically to her accounts of continuing mistreatment by her current boss and boyfriend. Then one day an unusual incident occurred, which graphically illuminated her dynamics.

She called me one morning in great distress. She had had an extremely unsettling altercation with her boyfriend and felt panicky and suicidal. She felt she could not possibly wait for the next group meeting, still four days off, and pleaded for an immediate individual session. Although it was greatly inconvenient, I rearranged my appointments that afternoon and scheduled time to meet her. Approximately thirty minutes before our meeting, she called and left word with my secretary that she would not be coming in after all.

When, in the next group meeting, I inquired what had happened, Linda stated that she had decided to cancel the emergency session because she was feeling slightly better by the afternoon, and that she knew I had a rule that I would see a patient only one time in an emergency during the whole course of group therapy. She therefore thought it might be best to save that time until some future point when she might be even more in crisis.

I found her response bewildering. I had never made such a rule; I never refuse to see someone in real crisis. Nor did any of the other members of the group recall my having issued such a dictum. But Linda stuck to her guns: she insisted that she had heard me say it, and was dissuaded neither by my denial nor by the unanimous consensus of the other group members. The discussion became circular, defensive, and acrimonious.

This incident, unfolding in the social microcosm of the group, was highly informative and allowed us to obtain an important perspective on Linda's responsibility for some of her problematic relationships with men. Up until that point, the group had had to rely entirely on her portrayal of these relation-

ships. Linda's accounts were convincing, and the group had come to accept her vision of herself as victim of "all those damn men out there." An examination of the here-and-now incident indicated that Linda had distorted her perceptions of at least one important man in her life: her therapist. Moreover, and this is extremely important, she had distorted the incident *in a highly predictable fashion*: she experienced me as far more uncaring, insensitive, and authoritarian than I really was.

This was new data. And it was extremely convincing data—data that was displayed before the eyes of all the members. For the first time, the group began to wonder about the accuracy of Linda's accounts of her relationships with men. Undoubtedly, she accurately portrayed her feelings, but it became apparent that there were perceptual distortions at work: because of her expectations of men and her highly conflicted relationships with them, she misperceived their actions toward her.

But there was more yet to be learned from the social microcosm. An important piece of data was the tone of the discussion: the defensiveness, the irritation, the anger. In time I, too, became irritated by the thankless inconvenience I had suffered by changing my schedule to meet with Linda. I was further irritated by her insistence that I had proclaimed a certain insensitive rule when I (and the rest of the group) knew I had not. I fell into a reverie in which I asked myself, "What would it be like to live with Linda all the time instead of an hour and a half a week?" If there were many such incidents, I could imagine myself often becoming angry, exasperated, and uncaring toward her. This is a particularly clear example of the concept of the self-fulfilling prophecy described on page 20. Linda predicted that men would behave toward her in a certain way and then, unconsciously, operated so as to bring this prediction to pass.

### Men Who Could Not Feel

Allen, a thirty-year-old unmarried scientist, sought therapy for a single, sharply delineated problem: he wanted to be able to feel sexually stimulated by a woman. Intrigued by this conundrum, the group searched for an answer. They investigated his early life, sexual habits, and fantasies. Finally, baffled, they turned to other issues in the group. As the sessions continued, Allen seemed impassive and insensitive to his own and others' pain. On one occasion, for example, an unmarried member in great distress announced in sobs that she was pregnant and was planning to have an abortion. During her account she also mentioned that she had had a bad PCP trip. Allen, seemingly unmoved by her tears, persisted in questioning her intellectually about the effects of "angel dust" and was puzzled when the group turned on him because of his insensitivity.

So many similar incidents occurred that the group came to expect no emotion from him. When directly queried about his feelings, he responded as if he had been addressed in Sanskrit or Aramaic. After some months the group formulated an answer to his oft-repeated question, "Why can't I have sexual feelings toward a woman?" They asked him to consider instead why he couldn't have any feelings toward anybody.

Changes in his behavior occurred very gradually. He learned to spot and identify feelings by pursuing telltale autonomic signs: facial flushing, gastric tightness, sweating palms. On one occasion a volatile woman in the group threatened to leave the group because she was exasperated trying to relate to "a psychologically deaf and dumb goddamned robot." Allen again remained impassive, responding only, "I'm not going to get down to your level."

However, the next week when he was asked about the feelings he had taken home from the group, he said that after the meeting he had gone home and cried like a baby. (When he left the group a year later and looked back at the course of his therapy, he identified this incident as a critical turning point.) Over the ensuing months he was more able to feel and to express his feelings to the other members. His role within the group changed from that of tolerated mascot to that of accepted compeer, and his self-esteem rose in accordance with his awareness of the members' increased respect for him.

In another group Ed, a forty-seven-year-old engineer, sought therapy because of loneliness and his inability to find a suitable mate. Ed's pattern of social relationships was barren: he had never had close male friends and had only sexualized, unsatisfying, short-lived relationships with women who ultimately and invariably rejected him. His good social skills and lively sense of humor resulted in his being highly valued by other members in the early stages of the group.

As time went on and members deepened their relationships with one another, however, Ed was left behind: soon his experience in the group resembled closely his social life outside the group. The most obvious aspect of his behavior was his limited and offensive approach to women. His gaze was directed primarily toward their breasts or crotch; his attention was voyeuristically directed toward their sexual lives; his comments to them were typically simplistic and sexual in nature. Ed considered the men in the group unwelcome competitors: for months he did not initiate a single transaction with a man.

With so little appreciation for attachments, he, for the most part, considered people interchangeable. For example, when a member described her obsessive fantasy that her boyfriend, who was often late, would be killed in an automobile accident, Ed's response was to assure her that she was young, charming, and attractive and would have little trouble finding another man of at least equal quality. To take another example, Ed was always puzzled when other

members appeared troubled by the temporary absence of one of the co-therapists or, later, by the impending permanent departure of a therapist. Doubtless, he suggested, there was, even among the students, a therapist of equal competence. (In fact, he had seen in the hall a bosomy psychologist, whom he would particularly welcome as therapist.)

He put it most succinctly when he described his MDR (minimum daily requirement) for affection; in time it became clear to the group that the identity of the MDR supplier was incidental to Ed—far less relevant than its dependability.

Thus evolved the first phase of the group therapy process: the display of interpersonal pathology. Ed did not relate to others so much as he used them as equipment, as objects to supply his life needs. It was not long before he had recreated in the group his habitual—and desolate—interpersonal universe: he was cut off from everyone. Men reciprocated his total indifference; women, in general, were disinclined to service his MDR, and those women he especially craved were repulsed by his narrowly sexualized attentions.

### THE SOCIAL MICROCOSM: A DYNAMIC INTERACTION

There is a rich and subtle dynamic interplay between the group member and the group environment. Members shape their own microcosm, which in turn pulls characteristic defensive behavior from each. The more spontaneous interaction there is, the more rapid and authentic will be the development of the social microcosm. And that in turn increases the likelihood that the central problematic issues of all the members will be evoked and addressed.

For example, Nancy, a young borderline patient, entered the group because of a disabling depression, a subjective state of disintegration, and a tendency to develop panic when left alone. All of Nancy's symptoms had been intensified by the threatened breakup of the small commune in which she lived. She had long been sensitized to the breakup of nuclear units; as a child she had felt it was her task to keep her volatile family together, and now as an adult she nurtured the fantasy that when she married, the various factions among her relations would be permanently reconciled.

How were Nancy's dynamics evoked and worked through in the social microcosm of the group? Slowly! It took time for these concerns to manifest themselves. At first, sometimes for weeks on end, Nancy would work comfortably on important but minor conflict areas. But then, certain events in the group would fan her major, smoldering concerns into anxious conflagration. For example, the absence of a member would unsettle her. In fact, much later,

in a debriefing interview at the termination of therapy, Nancy remarked that she often felt so stunned by the absence of any member that she was unable to participate for the entire session.

Even tardiness troubled her and she would chide members who were not punctual. When a member thought about leaving the group, Nancy grew deeply concerned and could be counted on to exert maximal pressure upon the member to continue, regardless of the person's best interests. When members arranged contacts outside the group meeting, Nancy became anxious at the threat to the integrity of the group. Sometimes members felt smothered by Nancy. They drew away and expressed their objections to her phoning them at home to check on their absence or lateness. Their insistence that she lighten her demands on them simply aggravated Nancy's anxiety, causing her to increase her protective efforts.

Though she longed for comfort and safety in the group, it was, in fact, the very appearance of these unsettling vicissitudes that made it possible for her major conflict areas to become exposed and to enter the stream of the therapeutic work.

Not only does the small group provide a social microcosm in which the maladaptive behavior of members is clearly displayed but it also becomes a laboratory in which is demonstrated, often with great clarity, the meaning and the dynamics of the behavior. The therapist sees not only the behavior but also the events triggering it and sometimes, more important, the anticipated and real responses of others.

Leonard, for example, entered the group with a major problem of procrastination. In Leonard's view, procrastination was not only a problem but an explanation. It explained his failures, both professionally and socially; it explained his discouragement, depression, and alcoholism. And yet it was an explanation that obscured meaningful explanation.

In the group we became well acquainted with Leonard's procrastination. It served as his supreme mode of resistance to therapy when all other resistance had failed. When members worked hard with Leonard, and when it appeared that part of his neurotic character was about to be uprooted, he found ways to delay the group work. "I don't want to be upset by the group today," he would say, "this new job is make or break for me." "I'm just hanging on by my fingernails"; "Give me a break—don't rock the boat"; "I'd been sober for three months until the last meeting caused me to stop at the bar on my way home." The variations were many, but the theme was consistent.

One day Leonard announced a major development, one for which he had long labored: he had quit his job and obtained a position as a teacher. Only a single step remained: getting a teaching certificate, a matter of filling out an application requiring approximately two hours' labor.

Only two hours, and yet he could not do it! He delayed until the allowed time had practically expired and, with only one day remaining, informed the group about the deadline and lamented the cruelty of his personal demon, procrastination. Everyone in the group, including the therapists, experienced a strong desire to sit Leonard down, possibly even in one's lap, place a pen between his fingers, and guide his hand along the application form. One patient, the most mothering member of the group, did exactly that: she took him home, fed him, and schoolmanned him through the application form.

As we began to review what had happened, we could now see his procrastination for what it was: a plaintive, anachronistic plea for a lost mother. Many things then fell into place, including the dynamics behind Leonard's depressions (another even more desperate plea for love), alcoholism, and compulsive overeating.

The idea of the social microcosm is, I believe, sufficiently clear: *if the group is so conducted that the members can behave in an unguarded, unself-conscious manner, they will, most vividly, recreate and display their pathology in the group.* Furthermore, in the *in vivo* drama of the group meeting, the trained observer has a unique opportunity to understand the dynamics of each patient's behavior.

## RECOGNITION OF BEHAVIORAL PATTERNS IN THE SOCIAL MICROCOSM

If therapists are to turn the social microcosm to therapeutic use, they must first learn to identify the patients' recurrent maladaptive interpersonal patterns. In the incident involving Leonard, the therapist's vital clue was the emotional response of members and leaders to Leonard's behavior. These emotional responses are valid and indispensable data: they should not be overlooked or underestimated. The therapist or other group members may feel angry toward a member, or exploited, or sucked dry, or steamrollered, or intimidated, or bored, or tearful, or any of the infinite number of ways one person can feel toward another.

These feelings represent data—a bit of the truth about the other person—and should be taken seriously by the therapist. If the feelings elicited in others are highly discordant with the feelings that the patient would like to engender in others, or if the feelings aroused are desired, yet inhibit growth (as in the case of Leonard), then therein lies an important part of the patient's problem. It is to this phenomenon that the therapist should direct attention.

There are many complications inherent in this thesis. Some critics might

say that a strong emotional response is often due to pathology not of the subject but of the respondent. If, for example, a self-confident, assertive man evokes strong feelings of fear, intense envy, or bitter resentment in another man, we can hardly conclude that the response is reflective of the former's pathology.

Thus the emotional response of another member is not sufficient: therapists need confirmatory evidence. They look for repetitive patterns over time and for multiple responses—that is, the reactions of several other members (referred to as *consensual validation*) to the individual. And most of all, therapists rely on the most valuable evidence of all: their own emotional responses.

But, the same critics might say. "How can we be sure the therapists' reactions are 'objective'? Surely therapists also have their blind spots, their own areas of interpersonal conflict and distortion." I will address this issue fully in later chapters on training and on the therapist's tasks and techniques, but for now note only that this argument is a powerful reason for therapists to know themselves as fully as possible. Thus it is incumbent that the neophyte group therapist embark on a lifelong journey of self-exploration, a journey that includes both individual and group therapy.

None of this is meant to imply that therapists should not take seriously the responses and feedback of *all* patients, including those who are highly disturbed. Even the most exaggerated, irrational responses contain a core of reality. Furthermore, the disturbed patient may be a valuable, accurate source of feedback at other times (no individual is highly conflicted in every area). Lastly, of course, an idiosyncratic response contains much information about the respondent.

This final point constitutes a basic axiom for the group therapist. Not infrequently, members of a group respond very differently to the same stimuli. An incident may occur in the group that each of seven or eight members perceives, observes, and interprets differently. *One common incident and eight different responses*—how can that be? There seems only one plausible explanation: there are *eight different inner worlds*. Splendid! After all, the aim of therapy is to help patients understand and alter their inner worlds. Thus, analysis of these differing responses is a *royal road—a via regia—into the inner world of the group member*.

For example, consider the first illustration offered in this chapter, the group containing Valerie, a flamboyant, controlling member. According to their inner worlds, the group members responded very differently to her, ranging from obsequious acquiescence to lust and gratitude to impotent fury or effective confrontation.

Or, again, consider certain structural aspects of the group meeting: members have markedly differing responses to sharing the group's or the therapist's attention, to disclosing themselves, to asking for help or helping others.

Nowhere are such differences more apparent than in the transference—the members' responses to the leader: the same therapist will be experienced by different members as warm, cold, rejecting, accepting, competent, or bumbling.

## THE SOCIAL MICROCOSM—IS IT REAL?

I have often heard group members challenge the veracity of the social microcosm. They may claim that their behavior in this particular group is atypical, not at all representative of their normal behavior. Or that this is a group of troubled individuals who have difficulty perceiving them accurately. Or even that group therapy is not real; it is an artificial, contrived experience that distorts rather than reflects one's real behavior. To the neophyte therapist, these arguments may seem formidable, even persuasive, but they are in fact truth-distorting. In one sense, the group *is* artificial: members do not choose their friends from the group; they are not central to one another; they do not live, work, or eat together; though they relate in a personal manner, their entire relationship consists of meetings in a professional's office once or twice a week; and the relationships are transient—the end of the relationship is built into the social contract at the very beginning.

When faced with these arguments, I often think of Earl and Marguerite, two patients in a group I led long ago. Earl had been a member of the group for four months when Marguerite was introduced. They both blushed to see each other since, by chance, they had only a month previously gone on a Sierra Club camping trip together for a night and been "intimate." Neither wanted to be in the group with the other. To Earl, Marguerite was a foolish, empty girl, "a mindless piece of ass," as he was to put it later in the group. To Marguerite, Earl was a dull nonentity, whose penis she had made use of as a means of retaliation against her husband.

They worked together in the group once a week for about a year. During that time, they came to know each other intimately in a fuller sense of the word: they shared their deepest feelings; they weathered fierce, vicious battles; they helped each other through suicidal depressions; and, on more than one occasion, they wept for each other. Which was the real world and which the artificial?

The point is that the group can be far more real than the world out there. The group attempts to identify and eliminate social, prestige, or sexual games; members go through vital life experiences together; the reality-distorting facades are doffed as members try hard to be honest with one another. How many times have I heard a group member say, "This is the first time I have

ever told this to anyone"? These people are not strangers. Quite the contrary: they know one another deeply and fully. Yes, it is true that members spend only a small fraction of their lives together. But psychological reality is not equivalent to physical reality. Psychologically, group members spend infinitely more time together than the one or two meetings a week when they physically occupy the same office.

## OVERVIEW

Let me now return to the primary task of this chapter: to define and describe the therapeutic factor of interpersonal learning. All the necessary premises have been posited and described in this discussion of:

1. The importance of interpersonal relationships
2. The corrective emotional experience
3. The group as a social microcosm.

I have discussed these components separately. Now, if we recombine them into a logical sequence, the mechanism of interpersonal learning as a therapeutic factor becomes evident:

I. Psychological symptomatology emanates from disturbed interpersonal relationships. The task of psychotherapy is to help the patient learn how to develop distortion-free, gratifying interpersonal relationships.

II. The psychotherapy group, provided its development is unhampered by severe structural restrictions, evolves into a social microcosm, a miniaturized representation of each patient's social universe.

III. The group members, through feedback from others and self-observation, become aware of significant aspects of their interpersonal behavior: their strengths, their limitations, their interpersonal distortions, and the maladaptive behavior that elicits unwanted responses from other people. The patient, who will often have had a series of disastrous relationships and subsequently suffered rejection, has failed to learn from these experiences because others, sensing the person's general insecurity and abiding by the rules of etiquette governing normal social interaction, have not communicated the reasons for rejection. Therefore, and this is important, *patients have never learned to discriminate between objectionable aspects of their behavior and a self-concept as a totally unacceptable person.* The therapy group, with its encouragement of accurate feedback, makes such discrimination possible.

IV. In the therapy group, a regular interpersonal sequence occurs:

- A. Pathology display: the member displays his or her behavior.
- B. Through feedback and self-observation, patients
  1. Become better witnesses of their own behavior
  2. Appreciate the impact of that behavior upon
    - a. the feelings of others
    - b. the opinions that others have of them
    - c. the opinions they have of themselves.

V. The patient who has become fully aware of this sequence also becomes aware of personal responsibility for it: each individual is the author of his or her own interpersonal world.

VI. Individuals who fully accept personal responsibility for the shaping of their interpersonal world may then begin to grapple with the corollary of this discovery: *if they created their social-relational world, then they have the power to change it.*

VII. The depth and meaningfulness of these understandings are directly proportional to the amount of affect associated with the sequence. The more real and the more emotional an experience, the more potent is its impact; the more distant and intellectualized the experience, the less effective is the learning.

VIII. As a result of this group therapy sequence, the patient gradually changes by risking new ways of being with others. The likelihood that change will occur is a function of

- A. the patient's motivation for change and the amount of personal discomfort and dissatisfaction with current modes of behavior
- B. the patient's involvement in the group—that is, how much the patient allows the group to matter
- C. the rigidity of the patient's character structure and interpersonal style.

IX. Once change, even modest change, occurs, the patient appreciates that some feared calamity, which had hitherto prevented such behavior, has been irrational; *this new behavior has not resulted in such calamities as death, destruction, abandonment, derision, or engulfment.*

X. The social microcosm concept is bidirectional: not only does outside behavior become manifest in the group but behavior learned in the group is eventually carried over into the patient's social environment, and alterations appear in patients' interpersonal behavior outside the group.

XI. Gradually an *adaptive spiral* is set in motion, at first inside and then outside the group. As a patient's interpersonal distortions diminish, his or her ability to form rewarding relationships is enhanced. Social anxiety decreases; self-esteem rises; the need for self-concealment diminishes. *Others respond*

positively to this behavior and show more approval and acceptance of the patient, which further increases self-esteem and encourages further change. Eventually the adaptive spiral achieves such autonomy and efficacy that professional therapy is no longer necessary.

Each of the steps of this sequence requires different and specific facilitation by the therapist. At various points, for example, the therapist must offer specific feedback, encourage self-observation, clarify the concept of responsibility, exhort the patient into risk taking, disconfirm fantasized calamitous consequences, reinforce the transfer of learning, and so on. Each of these tasks and techniques will be fully discussed in chapters 5 and 6.

## TRANSFERENCE AND INSIGHT

Before concluding the examination of interpersonal learning as a mediator of change, I wish to call attention to two concepts that deserve further discussion. Transference and insight play too central a role in most formulations of the therapeutic process to be passed over lightly. I rely heavily on both of these concepts in my therapeutic work and do not mean to slight them. What I have done in this chapter is to embed them both into the factor of interpersonal learning.

*Transference* is a specific form of interpersonal perceptual distortion. In individual psychotherapy, the recognition and the working through of this distortion is of paramount importance. In group therapy, working through interpersonal distortions is, as we have seen, of no less importance; however, *the range and variety of distortions are considerably greater*. Working through the transference—that is, the distortion in the relationship to the therapist—now becomes only one of a series of distortions to be examined in the therapy process.

For many patients, perhaps for the majority, it is the most important relationship to work through since the therapist is the personification of parental images, of teachers, of authority, of established tradition, of incorporated values. But most patients are also conflicted in other interpersonal domains: for example, power, assertiveness, anger, competitiveness with peers, intimacy, sexuality, generosity, greed, envy.

Considerable research emphasizes the importance many members place on working through relationships with other members rather than with the leader.<sup>27</sup> To take one example, a team of researchers asked members, in a twelve-month follow-up of a short-term crisis group, to indicate the source of the help each had received. Forty-two percent felt that the group members and not the therapist had been helpful, and 28 percent responded that both had been of aid. Only 5 percent stated that the therapist alone was a major contributor to change.<sup>28</sup>

This corpus of research has important implications for the technique of the group therapist: rather than focusing exclusively on the patient-therapist relationship, therapists must facilitate the development and working-through of interactions among members. I will have much more to say about these issues in chapters 6 and 7.

*Insight* defies precise description; it is not a unitary concept. I prefer to employ it in the general sense of "sighting inward"—a process encompassing clarification, explanation, and derepression. Insight occurs when one discovers something important about oneself—about one's behavior, one's motivational system, or one's unconscious.

In the group therapy process, patients may obtain insight on at least four different levels:

1. Patients may gain a more objective perspective on their *interpersonal presentation*. They may for the first time learn how they are seen by other people: as tense, warm, aloof, seductive, bitter, arrogant, pompous, obsequious, and so on.
2. Patients may gain some understanding into their more *complex interactional patterns of behavior*. Any of a vast number of patterns may become clear to them: for example, that they exploit others, court constant admiration, seduce and then reject or withdraw, relentlessly compete, plead for love, or relate only to the therapist or to the men or the women members.
3. The third level may be termed *motivational insight*. Patients may learn why they do what they do to and with other people. A common form this type of insight assumes is learning that one behaves in certain ways because of the belief that different behavior would bring about some catastrophe: one might be humiliated, scorned, destroyed, or abandoned. Aloof, detached patients, for example, may understand that they shun closeness because of fears of being engulfed and losing themselves; competitive, vindictive, controlling patients may understand that they are frightened of their deep, insatiable cravings for nurturance; timid, obsequious individuals may dread the eruption of their repressed, destructive rage.
4. A fourth level of insight, *genetic insight*, attempts to help patients understand how they got to be the way they are. Through an exploration of personal developmental history, the patient understands the genesis of current patterns of behavior. The theoretical framework and the language in which the genetic explanation is couched are, of course, largely dependent on the therapist's school of conviction.

I have listed these four levels in the order of degree of inference. An unfortunate and long-standing conceptual error has resulted, in part, from the ten-

dency to equate a "superficial-deep" sequence with this "degree of inference" sequence. Furthermore, deep has become equated with "profound" or "good," and superficial with "trivial," "obvious," or "inconsequential." Psychoanalysts have disseminated the belief that the more profound the therapist, the deeper the interpretation (from a genetic perspective), and the more complete the treatment. *There is, however, not a single shred of evidence to support this contention.*

Every therapist has encountered patients who have achieved considerable genetic insight based on some accepted theory of child development—be it that of Freud, Klein, Winnicott, Kernberg, Kohut, or another—and yet made no therapeutic progress. On the other hand, it is commonplace for significant clinical change to occur in the absence of genetic insight. *Nor is there a demonstrated relationship between the acquisition of genetic insight and the persistence of change.* In fact, there is much reason to question the validity of our most revered assumptions about the relationship between types of early experience and adult behavior and character structure.<sup>29</sup>

A fuller discussion of causality would take us too far afield from interpersonal learning, but I will return in depth to the issue in chapters 5 and 6. For now, it is sufficient to emphasize that there is little doubt that intellectual understanding lubricates the machinery of change. It is important that insight—"sighting in"—occur, but in its generic, not its genetic, sense. And psychotherapists need to disengage the concept of "profound" or "significant" intellectual understanding from temporal considerations. Something that is deeply felt or has deep meaning for a patient may or—as is usually the case—may not be related to the unraveling of the early genesis of behavior.